Huisartsenpraktijk van A tot Z

Registration form

Fill in this form diligent and return it to the practice. Please take a valid identification with you. Information about the practice can be found on our website: www.huisartsenpraktijkvanatotz.nl

Personal data

Last name:				
Initals:		First name:		
Date of birth:			Gender:	M/F
If one of your childeren is younger than 16: do you share custody of the child with another parent? If so, does this parent also agree with this registration?			Yes / No Yes / No / Unknown	
Praktijkmedewerker: voer Identiteitscontrole uit aan de hand van geldig ID (invullen bij checks) *Identificatiesoort:* *Identificatienummer:*				

Adressdata

Streetname:			
Postcode:		Place of residence:	
Telephonenumber:		Mobilenumber:	
E-mail:			
Living together with: (*if applicable)*			

Insurance data

Name insurance:		UZOVI nr. : (if known)	
Citizen service number:		Policy number of health insurance:	

Family doctor/farmacy

Family doctor	Practice A tot Z : Dr. Asrian /Dr. Zilverschoon
Farmacy	○ Zuidpolder ○ Epicurus

Name:_______________________________ Date of birth:_________________________________

Data previous family doctor/farmacy

Name previous family doctor:	
Adress and place of residence:	

Name farmacy:	
Adress and place of residence:	

Permission

By filling in this form you register at our practice. You grant permission for us to request your data from your previous general practitioner and pharmacy.
If you are filling in this form for a child under the age of 16 and you share parental custody, the other parent (or guardian) must also agree. From the age of 12, the child must also sign.
A child/young adult from 16 years of age gives permission for registration and for requesting data.

We request you to inform your previous general practitioner (and pharmacy) about your transfer to our practice. They will send your file to us with your permission.

If you register at Huisartsencentrum Zuid, you hereby also give permission for us to share your medical data with the GP center.

Date: **Signature:**

Under the age of 16 years, a signature of both parents is required!

Name Parent 1:	*Name parent 2:*
Siganture parent 1:	*Signature parent 2*

Medicaldata

Are you known with sensitivities, allergies or side effects to medicines or excipients?

○ no ○ Yes (Fill in the information below)

Medication/excipients / substance	Side effect/ hypersensitivity /allergic reaction

Are you taking any medicines?

○ No ○ Yes (Fill in the medication that you use below)

Name of the medicine	***How many mg / ml***	***Use per day or week***

Do you have a will? (Like a do not resuscitate statement, medical treatment ban and/or euthanasia request):

Name:_____________________________ date of birth:_______________________________

Do you use any over-the-counter remedies/ alternative medication/ nutritional supplements?

Like medication or supplements you can buy at the farmacy or drugstore?

○ No ○ Yes (Fill in what you use below)

Do the following diseases occur in your family, or do you have them yourself?

	Yourself		In your family	
Diabetes mellitus	○ No	○ Yes	○ No	○ Yes
heart and vascular diseases	○ No	○ Yes	○ No	○ Yes
- hypertensia	○ No	○ Yes	○ No	○ Yes
- hypercholesterolemia	○ No	○ Yes	○ No	○ Yes
- Stroke (CVA or TIA)	○ No	○ Yes	○ No	○ Yes
- heart problems	○ No	○ Yes	○ No	○ Yes
- vasculair problems (claudicatio intermittens)	○ No	○ Yes	○ No	○ Yes
Kidney disease	○ No	○ Yes	○ No	○ Yes
Asthma or COPD	○ No	○ Yes	○ No	○ Yes
Eczema, hay fever, allergies	○ No	○ Yes	○ No	○ Yes
Stomach / bowel disease	○ No	○ Yes	○ No	○ Yes
Bowel cancer	○ No	○ Yes	○ No	○ Yes
Breast cancer	○ No	○ Yes	○ No	○ Yes
Other form of cancer	○ No	○ Yes	○ No	○ Yes
Epilepsy	○ No	○ Yes	○ No	○ Yes

Other diseases that may be of concern

………………………………

Do hereditary diseases/disorders run in your family?

○ No ○ Yes (If so, write down below)

Name hereditary condition

What vaccinations have you recieved in the past?

Children's vaccination program	Yes / No	Flu vaccination	Yes / No
Extra vaccinations (for example hepatitis B)	Yes / No	Travelers vaccinations	Yes / No
If so, What kind of vaccinations:		If so, what kind:	

Are you being treated bij a medical specialist?

○ No ○ Yes (Fill in further information below)

Name of the specialist	*Name of the hospital*

Have you had any surgeries?

○ No ○ Yes (Fill in further information below)

What kind of surgerie?	*Surgery date:*

Name:______________________________ Date of birth:________________________________

Have you been in a serious accident?
○ No ○ Yes (Fill in further information below)

Wat kind of accident? Any concequences?

Are there any topics that you think the GP should be aware of?
○ No ○ Yes (Fill in further information below)

<u>Lifestyle</u>

What is your weight and length:
………. kg ………. cm

Do you smoke?
○ No ○ Yes (Fill in further information below)

What do you smoke?	*Howmuch per day / week?*

Do you use any alcohol?
○ No ○ yes (Fill in further information below)

What do you drink?	*Howmuch per day/week?*

Do you use any drugs?
○ No ○ Yes (Fill in further information below)

What kind of drugs do you use?	*Howmuch per day/week?*

Checks in te vullen door de praktijk / Checks done by practice assistent	**Datum**	**Paraaf**
Identiteitscontrole uitgevoerd adhv geldig legitimatiebewijs		
Dossier ingevoerd in HIS		
Patiënt ingevoerd als: passant / vaste patiënt		
Medicatie Overzicht (BMG) opgevraagd bij vorige apotheek (niet verplicht = risico inschatting): ja / nee (n.v.t.)		
Medicatie Overzicht vorige apotheek ingevoerd in medicatiedossier (denk ook aan de allergieën en contra indicaties)		
Kennismakingsgesprek gepland HA: ja / nee / n.v.t.		
Ruiters toegevoegd dossier: ja / nee / n.v.t.		
COV		
ION		
Verificatie door huisarts		
Toestemming LSP verwerkt		

Permission form

Your medical data available through the LSP

☐ **YES**

I **do** authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the 'Your medical data available through the LSP (National Exchange Point)' leaflet.

☐ **NO**

I **do not** authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the 'Your medical data available through the LSP (National Exchange Point)' leaflet.

GP or pharmacy details

Which healthcare provider does this form concern? ☐ my GP ☐ my pharmacy

Name: ....

Address: ....

Postcode and town: ....

Should you wish to grant permission to another healthcare provider as well? Please complete a new permission form.

My details do not forget to sign the form

Family name: .... Initials: .... ☐ M ☐ F

Address: ....

Postcode and town: ....

Date of birth: ....

Do you wish to give permission for your children?

- For children up to age 12: as a parent or guardian, you have to give your permission. Please use this form.
- For children aged 12 to 16 who wish to give their permission: both the parent or guardian and the child need to sign the form.
- Children aged 16 and over need to give permission themselves and complete the form themselves.

Details of my children

Complete the below details of the children with respect to whom you wish to give permission. Do not forget to provide your own signature. Do you have more than two children? Please complete a new permission form.

Personal and family name: .... ☐ M ☐ F

Date of birth: .... Child's signature: .... ☐ YES ☐ NO

Personal and family name: .... ☐ M ☐ F

Date of birth: .... Child's signature: .... ☐ YES ☐ NO

Do you have more than two children? Please complete a new permission form.

Date: .... Signature parent or guardian: ....

Submit this form to the GP of pharmacy your permission concerns.